EXAMPLES OF PREAMBLES OF VARIOUS STATE PCMH LAWS AND EXECUTIVE ORDERS

MARLYLAND—SB 885 (Click here to read the entire law)

WHEREAS, Health care costs continue to increase, making it more difficult for individuals, families, and businesses to afford a health benefit plan; and

WHEREAS, The increase in health care costs is, in part, attributable to inadequate coordination of care among providers, difficulties accessing primary care, and a lack of engagement between patients and their primary care providers; and

WHEREAS, Patient centered medical homes enhance care coordination and promote high quality, cost–effective care by engaging patients and their primary care providers; and

WHEREAS, The standards qualifying a primary care practice as a patient centered medical home, the quality measures that primary care practices must gather and report to demonstrate quality care, and the payment methodologies used to reimburse patient centered medical homes are inconsistent across carriers, and that inconsistency presents a major barrier to developing effective patient centered medical homes; and

WHEREAS, Patient centered medical homes are more likely to succeed if all carriers in Maryland use a single definition, a common set of quality measures, and a uniform payment methodology; and

WHEREAS, As a result of the complexity of establishing patient centered medical home programs, the State seeks to develop best practices in how to structure such a program through the experience to be gained in a State–sponsored patient centered medical home program and through programs that may be developed by private carriers and Medicaid managed care organizations; and

WHEREAS, Inconsistent access to health care services and variable quality of care provided to patients have been shown to result in poorer health outcomes and health care disparities; and

WHEREAS, It is desirable to have an ongoing process by which the effectiveness of patient centered medical homes can be evaluated; and

WHEREAS, Establishing and promoting patient centered medical homes in Maryland through both a State–sponsored program and similar programs implemented by private carriers and Medicaid managed care organizations will achieve higher quality health care for Maryland citizens and will, help slow the continuing escalation of health care costs, and improve health outcomes for Maryland citizens; now, therefore,

VERMONT—NO. 191 (Click here to read the entire law)

Sec. 1. FINDINGS
The general assembly finds that:
(1) The escalating costs of health care in the United States and in Vermont are not sustainable.
(2) The cost of health care in Vermont is estimated to increase by $1 billion, from $4.9 billion in 2010 to $5.9 billion, by 2012.
(3) Vermont's per-capita health care expenditures are estimated to be $9,463.00 in 2012, compared to $7,414.00 per capita in 2008.

(4) The average annual increase in Vermont per-capita health care expenditures from 2009 to 2012 is expected to be 6.3 percent. National per-capita health care spending is projected to grow at an average annual rate of 4.8 percent during the same period.
(5) From 2004 to 2008, Vermont's per-capita health care expenditures grew at an average annual rate of eight percent compared to five percent for the United States.
(6) At the national level, health care expenses are estimated at 18 percent of GDP and are estimated to rise to 34 percent by 2040.
(7) Vermont's health care system covers a larger percentage of the population than that of most other states, but still about seven percent of Vermonters lack health insurance coverage.
(8) Of the approximately 47,000 Vermonters who remain uninsured, more than one-half qualify for state health care programs, and nearly 40 percent of those who qualify do so at an income level which requires no premium.
(9) Many Vermonters do not access health care because of unaffordable insurance premiums, deductibles, co-payments, and coinsurance.
(10) In 2008, 15.4 percent of Vermonters with private insurance were underinsured, meaning that the out-of-pocket health insurance expenses exceeded five to 10 percent of a family's annual income depending on income level, or that the annual deductible for the health insurance plan exceeded five percent of a family's annual income. Out-of-pocket expenses do not include the cost of insurance premiums.
(11) At a time when high health care costs are negatively affecting families, employers, nonprofit organizations, and government at the local, state, and federal levels, Vermont is making positive progress toward health care reform.
(12) An additional 30,000 Vermonters are currently covered under state health care programs than were covered in 2007, including approximately12, 000 Vermonters who receive coverage through Catamount Health.
(13) Vermont's health care reform efforts to date have included the Blueprint for Health, a vision, plan, and statewide partnership that strives to strengthen the primary care health care delivery and payment systems and create new community resources to keep Vermonters healthy. Expanding the Blueprint for Health statewide may result in a significant system wide savings in the future.
(14) Health information technology, a system designed to promote patient education, patient privacy, and licensed health care practitioner best practices through the shared use of electronic health information by health care facilities, health care professionals, public and private payers, and patients, has already had a positive impact on health care in this state and should continue to improve quality of care in the future.
(15) Indicators show Vermont's utilization rates and spending are significantly lower than those of the vast majority of other states. However, significant variation in both utilization and spending are observed within Vermont which provides for substantial opportunity for quality improvements and savings.
(16) Other Vermont health care reform efforts that have proven beneficial to thousands of Vermonters include Dr. Dynasaur, VHAP, Catamount Health, and the department of health's wellness and prevention initiatives.
(17) Testimony received by the senate committee on health and welfare and the house committee on health care makes it clear that the current best efforts described in subdivisions (12), (13), (14), (15), and (16) of this section will not, on their own, provide health care coverage for all Vermonters or sufficiently reduce escalating health care costs.
(18) Only continued structural reform will provide all Vermonters with access to affordable, high quality health care.

(19) Federal health care reform efforts will provide Vermont with many opportunities to grow and a framework by which to strengthen a universal and affordable health care system.
(20) To supplement federal reform and maximize opportunities for this state, Vermont must provide additional state health care reform initiatives.

Sec. 2. PRINCIPLES FOR HEALTH CARE REFORM (extensive list)

Sec. 3. GOALS OF HEALTH CARE REFORM (another big list)

PENNSYLVANIA -- Executive Order 2007-05 (Click here to read the entire order)

Whereas, chronic diseases are the biggest threat to the health of Pennsylvania's residents, and seventy-five percent (75%) of the cost of health care can be traced to twenty-five percent (25%) of patients who have chronic diseases; and

Whereas, Pennsylvania has some of the highest rates of any state for potentially avoidable hospitalizations because those with chronic diseases have not received the needed episodic evidence based care in the community resulting in $1.7 billion in potentially avoidable hospital charges for Pennsylvanians with chronic disease in 2005; and

Whereas, there is a need to examine and change the covered benefits and methods of providing payments for chronic care in order for individuals to maintain a positive health status; and

Whereas, a nationally recognized Chronic Care Model is in use by the Veteran's Administration, federally qualified health centers and other locations in Pennsylvania and evaluations have demonstrated that the use of all of the components of this Chronic Care Model results in healthier patients, more satisfied providers and cost savings; and

Whereas, the components of this Chronic Care Model can be applied to a variety of chronic diseases in various health care settings.

Now, Therefore, I, Edward G. Rendell, Governor of the Commonwealth of Pennsylvania, by the virtue of the authority vested in me by the Constitution of the Commonwealth of Pennsylvania and other laws of the Commonwealth, do hereby establish the Governor's Chronic Care Management, Reimbursement and Cost Reduction Commission (hereafter referred to as the ''Commission'') and order and direct as follows:

IOWA—part of a larger health care bill --HF 2539 (Click here to read the entire law)

Medical Home

The purpose of a patient centered medical home is to provide for the coordination and integration of care, focused on prevention, wellness, and chronic care management, using a whole person orientation through a provider-directed medical practice. In addition, using a patient centered medical home should lower costs and improve quality through a tangible method of documentation and outcome based results. Providers that are certified patient centered medical homes will receive incentives for their continued participation. A patient centered medical home is not a “gatekeeper.”

STATE OF WASHINGTON: (Click here to read the entire law)

NEW SECTION. **Sec. 1.** The legislature declares that collaboration among public payors, private health carriers, third-party purchasers, and providers to identify appropriate reimbursement methods to align incentives in support of primary care medical homes is in the best interest of the public. The legislature therefore intends to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, for activities undertaken pursuant to pilots designed and implemented under section 2 of this act that might otherwise be constrained by such laws. The legislature does not intend and does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state and federal antitrust laws including, but not limited to, agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services.

IDAHO -- EXECUTIVE ORDER NO. 2010-10 (Click here to read the entire order)

ESTABLISHING AN IDAHO MEDICAL HOME COLLABORATIVE TO IMPLEMENT A PATIENT-CENTERED MEDICAL HOME MODEL OF CARE (COLLABORATIVE)

WHEREAS, in 2008, there were an average of 254.5 active physicians per 100,000 people in the US, ranging from a high of 405.4 in Massachusetts to a low of 174.2 in Mississippi; Idaho ranks 49th with 181.8. (American Association of Medical Colleges); and

WHEREAS, the need for a patient-centered approach to health care has become the focus of health care transformation nationally; and

WHEREAS, the importance of decreasing health care costs and increasing efficiency has become significant to Idaho's economy and the maintenance of a high performing health care system; and

WHEREAS, a process to address the transformation of Idaho's health care system to a Patient-Centered Medical Home model is needed by insurers and health care providers; and

WHEREAS, collaboration among public payers, private health carriers, third-party purchasers, and providers to identify appropriate reimbursement methods to align incentives in support of Patient-Centered Medical Homes is in the best interest of the public; and

WHEREAS, the establishment of this collaborative is in response to Idaho's growing need for more affordable and accessible healthcare as recognized by the Governor's Select Committee on Health Care; and

WHEREAS, the Idaho Governor's Select Committee on Health Care recommends working with key stakeholders to align the vision and key elements of a Patient-Centered Medical Home; and

WHEREAS, the Governor's Health Care Implementation Committee has identified the Patient-Centered Medical Home as a priority; and

WHEREAS, the Idaho Governor's Select Committee on Health Care also recommends developing a multi-payer pilot to test the efficacy of the Patient-Centered Medical Home;

NOW, THEREFORE, I, C.L. "BUTCH" OTTER, Governor of the State of Idaho, by the authority vested in me under the Constitution and laws of this state do hereby order:

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